

**U.S. Department of Labor**

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**Issue Date: 08 May 2007**

In the Matter of:  
**I.B.**, Survivor of  
**F.B.**

Claimant

v.

CASE NO. 2004-BLA-05866

**CONSOLIDATION COAL CO.**,  
Employer

and

**DIRECTOR, OFFICE OF WORKERS'**  
**COMPENSATION PROGRAMS**  
Party-In-Interest

Appearances:

Frederick K. Muth, Esquire  
For the Claimant

William S. Mattingly, Esquire  
For the Employer

Before: Daniel F. Solomon  
Administrative Law Judge

**DECISION AND ORDER ON REMAND**

***Denial of Benefits***

This case was remanded “for further proceedings consistent with [the] opinion” of the Benefits Review Board in an unpublished Decision and Order on June 23, 2006, which affirmed in part, vacated in part and remanded my prior Decision and Order issued on June 10, 2005.

**Background**

Claimant, IB, married the miner, FB (hereinafter “the miner”) on July 29, 1939. (DX 9). The miner filed two claims for benefits under the Act before his death. (DX 1 & 2). The first claim filed on April 6, 1973 resulted in a denial by the District Director finding that the miner had failed to establish that he was totally disabled due to pneumoconiosis. (DX 1). The action was pursued no further and is considered administratively closed. The miner filed a second claim for benefits on March 21, 1983. (DX2). The miner had received a 15% award from the West Virginia Occupational Pneumoconiosis Board in 1979, followed by an additional 15% award in 1982. (DX 2). A Decision and Order Approving the claim was issued by Judge John A. Gray on

July 25, 1988. (DX2). The employer appealed that decision to the Benefits Review Board (hereinafter “Board”), which affirmed Judge Gray in part, vacated in part and remanded the claim for further consideration. (DX2). On December 23, 1991, Judge Gray again awarded benefits. (DX 2). The employer made a motion for reconsideration that was subsequently denied. (DX 2). The decision on remand was appealed to the Board on September 15, 1992. (DX2). The Board affirmed Judge Gray’s decision on remand. (DX 2). The miner continued to receive benefits until the time of his death. The record shows that the miner passed away on September 17, 2002. DX 10, DX 4. The Record shows the Claimant has not remarried. (DX4). This has been stipulated. (DX35).

The instant survivor’s claim was filed on December 22, 2002. The District Director, in an initial determination issued May 29, 2003, concluded that the Claimant had failed to establish that pneumoconiosis had caused or contributed to the miner’s death and issued a Schedule for the submission of additional evidence. (DX 18). A Proposed Decision and Order was issued on September 10, 2003 denying benefits to the Claimant for having failed to establish that pneumoconiosis had caused or contributed to the death of the Claimant. No response was received within 30 days following the Proposed Decision and Order and the Order became final on October 10, 2003. The Claimant filed a response on October 20, 2003, requesting a formal hearing before an Administrative Law Judge. The submission was treated as a request for modification and a Proposed Order denying the request for modification was issued on January 16, 2004. (DX28) On January 23, 2004, the Claimant filed a request for a formal hearing before an Administrative Law Judge. (DX31). The claim was forwarded on February 26, 2004. (DX 35).

This matter was set for a formal hearing in Bluefield, West Virginia on August 25, 2004. On June 10, 2005, I issued a Decision and Order awarding benefits. The Decision was appealed to the Benefits Review Board (“BRB”). The case now comes before me on remand from the BRB, having been vacated in part and affirmed in part. A telephone hearing was held on April 9, 2007 to discuss the relevant evidentiary issues which formed the basis of the Board’s decision and remand. I left the record open for two weeks for submission of closing briefs and an additional five days following this date for submission of rebuttals.

#### APPLICABLE STANDARDS

Because the Claimant filed this application for benefits after March 31, 1980, the regulations set forth at part 718 apply. *Saginaw Mining Co. v. Ferda*, 879 F.2d 198, 204, 12 B.L.R. 2-376 (6th Cir. 1989).

The record indicates that the claimant’s last coal mine job was in Virginia. (DX5) Accordingly, this case arises within the jurisdiction of the United States of Appeals for the Fourth Circuit. See *Shupe v. Director, OWCP*, 12 BLR 1-200 (1989)(en banc).

This case represents a survivor’s claim for benefits. In order to receive benefits, the claimant must prove: (1) that the miner had pneumoconiosis, (2) the miner’s pneumoconiosis arose out of coal mine employment, and (3) the miner’s death was due to pneumoconiosis. 20 C.F.R. § 718.205(a). A miner’s death was due to pneumoconiosis if: (1) competent medical evidence establishes that the miner’s death was due to pneumoconiosis, (2) pneumoconiosis was a substantially contributing cause or factor leading to the miner’s death or the death was caused by complications of pneumoconiosis, or (3) the presumption for complicated pneumoconiosis at § 718.304 is applicable. 20 C.F.R § 718.205(c)(1) – (3). However, survivors are not eligible for benefits where the miner’s death was caused by a traumatic injury or the principal cause of death

as a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 C.F.R. § 718.205(c)(4).

A “substantially contributing cause” is any condition that hastens the miner’s death. 20 C.F.R. § 718.205(c)(5). Any condition that hastens the miner’s death is a substantially contributing cause of death for purposes of § 718.205. **Northern Coal Co. v. Director, OWCP**, 100 F.3d 871 (10<sup>th</sup> Cir. 1996) (a survivor is entitled to benefits if pneumoconiosis hastened the miner’s death “to any degree”); *See also Brown v. Rock Creek Mining Corp.*, 996 F.2d 812 (6<sup>th</sup> Cir. 1993)(J. Batchelder dissenting); **Island Creek Coal Co. v. Cooley**, 182 F.3d 917(6<sup>th</sup> Cir., 1999) ; **Wolf Creek Collieries v. Director, OWCP**, 298 F.3d 511(6<sup>th</sup> Cir.,2002). Similar to **Northern Coal**, the Sixth Circuit reaffirmed its holding in **Brown** to state that benefits are awarded to a survivor who establishes that “pneumoconiosis is a substantially contributing cause or factor leading to the miner’s death if it serves to hasten that death in any way.” **Griffith v. Director, OWCP**, 49 F.3d 184 (6<sup>th</sup> Cir. 1995); *but see Johnson v. Peabody Coal Co.*, 26 F.3d 618 (6<sup>th</sup> Cir. 1994) (survivor not awarded benefits where theory of entitlement was that “her husband was severely depressed at the time he committed suicide and that his depression was caused by his illnesses, including pneumoconiosis”). In a survivor’s claim filed after January 1, 1982, the evidence must establish that the decedent miner’s death was due to pneumoconiosis, and not due to a medical condition unrelated to pneumoconiosis. **Neeley v. Director, OWCP**, 11 BLR 1-85(1988).

The failure to prove any requisite element precludes a finding of entitlement. **Anderson v. Valley Camp of Utah, Inc.**, 12 B.L.R. 1-111 (1989); **Perry v. Director, OWCP**, 9 B.L.R. 1-1 (1986) 1-1 (1986) (en banc). “[T]he presence of evidence favorable to the claimant or even a tie in the proof will not suffice to meet that burden.” **Eastover Mining Co., v. Director, OWCP [Williams]**, 338 F.3d 501, No. 01-4604 (6<sup>th</sup> Cir. 2003) (citing *Greewich Collieries [Ondecko]*, 512 U.S. 267 at 281).

### **Mandate on Remand**

On appeal, the Employer alleged several errors, many of which were accepted by the Benefits Review Board.

The Board held that I must determine whether the record of the instant survivor’s claim includes the evidence from the miner’s claim and discuss the evidentiary limitations at 20 C.F.R. § 725.414.

Additionally, the Employer argues that I erred in finding the existence of pneumoconiosis by x-ray pursuant to Section 718.202(a)(1), since none of the x-rays I identified in my decision is classified according to the ILO classification system. The Board accepted the Employer’s contention and concluded that I erred in finding the existence of pneumoconiosis by x-ray at Section 718.202(a)(1), as the x-ray readings from the survivor’s claim that I considered are not classified according to the ILO classification system and are; therefore, insufficient to establish the existence of pneumoconiosis at Section 718.202(a)(1).

Employer next argues that I erred in finding that the preponderance of the medical opinion evidence establishes the existence of pneumoconiosis pursuant to Section 718.202(a)(4) because only Dr. Hippensteel did not diagnose pneumoconiosis. The Board agreed with the Employer and ruled that the evidence is insufficient to establish the existence of pneumoconiosis pursuant to Section 718.202(a)(4), as I improperly weighed the x-ray evidence at Section 718.202(a)(1) which affected my evaluation of the medical opinion evidence at Section 718.202(a)(4). Moreover, the Board held that I erred in relying solely on the numerical

superiority of the medical opinions to find the existence of pneumoconiosis established, without supplying additional rationale. *Adkins*, 958 F.2d 49, 16 BLR 2-61.

### **Request for Modification**

Any party to a proceeding may request modification at any time before one year from the date of the last payment of benefits or at any time before one year after the denial of a claim. 20 C.F.R. § 725.310(a). The survivor's claim filed on December 22, 2002, was denied by the District Director on October 10, 2003, concluding that the miner had failed to establish that the disease caused or contributed to the miner's death. Therefore, the instant request is for modification of the October 10, 2003 denial of the survivor's claim filed by the miner's spouse.<sup>1</sup>

In a survivor's claim, the sole ground for modification is that there has been a mistake in a determination of fact. This is because there can be no change in the deceased miner's condition.

The United States Supreme Court and federal Courts of Appeals have considered cases involving the mistake of fact factor listed in the regulations. In *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 257 (1971), the United States Supreme Court indicated that an Administrative Law Judge should review all evidence of record to determine if the original decision contained a mistake in a determination of fact. In considering a motion for modification, the ALJ is vested "with broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." See also *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir.1993); *Director, OWCP v. Drummond Coal Co.*, (Cornelius), 831 F.2d 240 (11th Cir. 1987).

### **Discussion**

The instant survivor's claim was filed on December 22, 2002. (DX5) The Claimant has requested modification of a denial of a survivor's claim. Modification of a denial in a survivor's claim is based on a determination of a mistake of fact. The determination is based on a review of the evidentiary record relevant to the survivor's claim. Furthermore, the Claimant argues that in the living miner's claim the award of benefits was based on a finding that the miner suffered from pneumoconiosis. Although this does not have the force and effect of collateral estoppel, it nevertheless constitutes strong evidence that which may be considered by the Court in favor of a finding of pneumoconiosis, the Claimant argues.

A mistake of fact analysis requires a review of all of the evidence of record. However, as the Board stated on remand, medical evidence from the prior living miner's claims must have been designated as evidence by one of the parties in order for it to have been included in the record relevant to the instant survivor's claim. BRB Decision and Order at 3. Both the Claimant and the Employer have designated medical reports and hospital treatment records as exhibits for admission into the record as part of this survivor's claim. Except for Director's Exhibit identified as DX11, neither party has designated evidence from the living miner's claim to be admitted as part of the record in the instant survivor's claim. The evidentiary record I review will consist of those exhibits so designated by the parties subsequent to the filing of the survivor's claim. The medical evidence has been summarized below.

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<sup>1</sup> The Claimant, widow of the miner, died on May 8, 2005. Her survivor's claim is being pursued by her estate.

### **Burden of Proof**

“Burden of proof” as used in this setting and under the Administrative Procedure Act<sup>2</sup> is that “[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof.”<sup>3</sup> “Burden of proof” means burden of persuasion, not merely burden of production. 5 U.S.C.A. § 556(d)4. The drafters of the APA used the term “burden of proof” to mean the burden of persuasion. See *Director, OWCP, Department of Labor v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251 (1994).<sup>4</sup>

A claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production, the obligation to come forward with evidence to support a claim.<sup>5</sup> Therefore, the Claimant cannot rely on the Director to gather evidence. A claimant, bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. See *Oggero v. Director, OWCP*, 7 BLR 1- 860 (1985).

### ***Length of Coal Mine Employment***

At the time of the decision in the miner’s claim for benefits under the Act, he was found to have established 36 ½ years of coal mine employment. (DX 2). I find this determination to be supported by the evidence of record in this matter. (DX 1 & 2). Therefore, I find that the miner was a miner within the meaning of the Act for 36 ½ years.

### ***Responsible Operator***

Consolidation Coal Co. has agreed that it is the properly identified responsible operator in this matter. (TR 9). I find this to be supported by the evidence of record. Therefore, I find that Consolidation Coal Co. is the proper responsible operator and is responsible for any award of benefits to the claimant.

### **Issues**

- 1.) Whether the miner suffered from pneumoconiosis;
- 2.) If the miner did suffer from pneumoconiosis, whether such condition arose out of his coal mine employment;
- 3.) Whether the miner’s death was due to pneumoconiosis; and
- 4.) Whether the claimant has established a mistake in a determination of fact.

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<sup>2</sup> 33 U.S.C. § 919(d) (“[N]otwithstanding any other provisions of this chapter, any hearing held under this chapter shall be conducted in accordance with “the APA”); 5 U.S.C. § 554(c)(2). Longshore and Harbor Workers Compensation Act (“LHWCA”), 33 U.S.C. §§ 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. §§ 932(a).

<sup>3</sup> The Tenth and Eleventh Circuits have held that the burden of persuasion is greater than the burden of production, *Alabama By-Products Corp. v. Killingsworth*, 733 F.2d 1511, 6 BLR 2-59 (11th Cir. 1984); *Kaiser Steel Corp. v. Director, OWCP [Sainz]*, 748 F.2d 1426, 7 BLR 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption was triggered, and the burden of proof shifted from a claimant to an employer/carrier.

<sup>4</sup> Also known as the risk of nonpersuasion, see 9 J. Wigmore, *Evidence* § 2486 (J. Chadbourn rev. 1981).

<sup>5</sup> *Id.*, also see *White v. Director, OWCP*, 6 BLR 1-368 (1983).

## Medical Evidence

### *Pulmonary Function Studies*

Date	EXH	Physician	HT	AGE	FEV <sub>1</sub>	FVC	FEV <sub>1</sub> /FVC	MVV	COOP
01/16/85	DX2	Dr. Zaldivar	69"	64	Pre 1.47	Pre 2.84	Pre 70%	-----	-----

### *Blood-Gas Studies*

Date	EXH	Physician	Altitude	pCO <sub>2</sub>	PO <sub>2</sub>	Comments
01/16/85	DX2	Dr. Zaldivar	0-2999	R – 35 E – 45	R – 80 E – 120	-----

### *Physician Opinion Evidence*

#### Dr. D.L. Rasmussen

Dr. Rasmussen issued a medical opinion on March 8, 2004. (CX1). Dr. Rasmussen reviewed multiple medical records dating as far back as 1980. The miner was employed in the coal mines from 1945 until 1982. For 29 of those years he was employed at the face as a hand loader initially, then as a loading machine operator and subsequently as a section foreman. The last 8 years of his employment he worked as an inspector. He was employed in the coal mines for many years prior to the institution of dust suppression. The miner had multiple x-ray readings indicating the presence of nodular and, occasionally irregular, opacities. These are quite consistent with coalworkers' pneumoconiosis. Based on his occupational dust exposure and his x-ray findings, he clearly suffered from coalworkers' pneumoconiosis. Pulmonary impairment in the miner is evident from several blood-gas studies performed by Drs. Piracha in 1980 and 1982, and one by Dr. Zaldivar in 1985. Dr. Piracha's study showed marked impairment in oxygen transfer and Dr. Zaldivar's revealed diffusing capacity 54% of predicted. Based on all of the evidence it is quite apparent that the miner suffers from a totally disabling chronic lung disease caused by his coal mine dust exposure. The miner was also a smoker and smoking generally causes an obstructive lung impairment, but has contributed to the miner's pulmonary impairment. The miner was in respiratory failure requiring increasing oxygen. He also suffered from other conditions such as Parkinsonism, which could have contributed to his death. His death, however, was the consequence of respiratory failure, which in significant part was the consequence of his coalworkers' pneumoconiosis. In summary, it can be stated that the miner suffered from a disabling and ultimately fatal chronic lung disease which was the consequence of both his cigarette smoking and especially his coal mine dust exposure with its resultant coal workers' pneumoconiosis. The miner's coal workers' pneumoconiosis was a major and substantial cause of his death.

#### Dr. George Zaldivar

Dr. Zaldivar issued a report pertaining to the miner's condition on July 19, 2004. (EX 3). The miner worked in the coal mines from 1945 to 1982. The miner stated that he had been a cigarette smoker from the age of 24 until 1982, smoking ½ pack per day. He estimated smoking for approximately 15 years. Dr. Zaldivar reviewed examination reports prepared by Drs. Taylor, Piracha, Modi, Frey, Bird, Faulkner, Patel, Aycoth, and Rasmussen, among others. He also reviewed hospital treatment reports, x-rays, and various laboratory tests. The dates of these

reports, examinations, and tests range from 1972 to 2002. Dr. Zaldivar concludes that there is evidence, based on radiographs, to diagnose coal workers' pneumoconiosis. The pulmonary impairment that exists is not related to his work as a coal miner. The pulmonary impairment is due to his pulmonary fibrosis was contributed to by his smoking habit, although the exact cause of the fibrosis is unknown but certainly not related to his occupation as a coal miner. Coal workers' pneumoconiosis never results in pulmonary fibrosis. Coal mine dust exposure did not play any role in his disability prior to his death. It did not contribute or hasten his death. It is important to note that it was his immobility and his inability to eat that was responsible for his death. The need for a gastric tube was not due to his lungs but due to his difficulty swallowing which was the result of Parkinson's disease.

#### Dr. George Zaldivar

Dr. Zaldivar also issued a rebuttal, dated August 17, 2004, to Dr. Rasmussen's report. Dr. Rasmussen recognized that Parkinson's disease was present and contributed to the death of the miner, although Dr. Rasmussen minimized its role. Dr. Rasmussen's opinion was that chronic lung disease was the consequence of cigarette smoking and coal mine dust exposure and that the miner had pneumoconiosis and dies as a result of the coal workers' pneumoconiosis. Dr. Zaldivar's conclusion is that the miner had all the pulmonary manifestations of pulmonary fibrosis. The CT scans revealed the presence of coal workers' pneumoconiosis, which is unrelated to coal mine dust exposure. The miner had interstitial pulmonary fibrosis unrelated to coal mining. The miner had many complications which led to his death. The major complication was Parkinson's disease. Dr. Rasmussen's report and conclusions do not alter Dr. Zaldivar's opinion regarding the causes of death of the miner.

#### Dr. Kirk Hippensteel

Dr. Hippensteel's report, dated August 2, 2004, was offered by the employer in this matter. (EX2). Dr. Hippensteel reviewed various medical reports, laboratory tests, and treatment records ranging in date from 1972 to 2002. His conclusion, based on this data, is that there is no conclusive proof, by x-rays, of coalworkers' pneumoconiosis. Because there exists many different x-ray interpretations over a period of time, this lack of consistency does not demonstrate a fixed or progressive process, as would be expected of coalworkers' pneumoconiosis. The pattern of changes in this miner, over time, are much more in keeping with non-pulmonary diseases causing his secondary respiratory impairment and abnormalities rather than coal workers' pneumoconiosis. A statement at the time of death by his caring physician that pneumoconiosis was present does not square with her diagnoses during treatment encounters before his death and is not sufficient to make a diagnosis of coal workers' pneumoconiosis.

#### Dr. Spagnolo

Dr. Spagnolo's report, dated July 4, 2004, was offered by the employer in this matter. (EX1). Dr. Spagnolo reviewed clinical reports, radiographic readings, medical opinions, and objective tests relating to the miner's physical condition. Based on the miner's employment, social, family, and smoking history, Dr. Spagnolo concludes that there is sufficient evidence to render a diagnosis of simple pneumoconiosis. According to the miner's spouse, the miner smoked approximately ½ pack of cigarettes per day for 40 years. And quit smoking in 1988. Dr. Taylor wrote that the miner smoked 1 pack per day for 30 years and quit smoking in 1983. The miner indicated in hearings that he started smoking in 1945.

The miner's lung function, measured on several occasions, showed no obstructive or restrictive impairment. There were fluctuating blood-gas values but these can be attributed to his cardiac disease and likely diastolic dysfunction. Thus, based on available data, it is Dr. Spagnolo's opinion that the miner did not have a respiratory impairment that would have prevented him from performing his last coal mine job. It is Dr. Spagnolo's opinion that the miner's death was unrelated to and not hastened, even briefly, by pneumoconiosis nor was pneumoconiosis a contributing factor in his death.

#### Dr. Spagnolo (Deposition)

Dr. Spagnolo was also deposed on August 4, 2004. (EX7) In his deposition, on direct examination, Dr. Spagnolo testified that he reviewed the miner's medical record and concluded that a diagnosis of coal workers' pneumoconiosis was justified based on the x-ray evidence. However, the existence of CWP does not automatically infer a respiratory impairment. It appears that the miner smoked for at least 20 years. There is no evidence in the medical data and records of this miner that he suffered from a restrictive or obstructive defect. Based on his blood-gas studies he may have had episodes of chronic bronchitis or heart failure. There are other diseases that can affect the oxygenation of blood. The direct causes of this miner's death were Parkinson's disease and made worse by his cardiac disease and then a terminal pneumonia on top of that. There is no evidence to indicate that coal mine dust played a role in causing or contributing or hastening any of those causes of his death. I could not say if smoking did or did not hasten his death. When questioned by opposing Counsel, Dr. Spagnolo stated that the x-ray evidence showed changes consistent with pneumoconiosis. The only impaired lung function that contribute in any way to the miner's death is the pneumonia, when the miner had severe Parkinsons disease.

#### Hospitalization/Treatment Records

Hospitalization records from April 6, 1999 through June 15, 2002, were offered by the Claimant. (DX11, DX12). Some of the hospital records contain digital x-rays from Princeton Community Hospital. However, I cannot consider these x-rays as they do not conform to the ILO classification standards required under the regulations. 29 C.F.R. §718.102(a).

<u>Date</u>	<u>Facility</u>	<u>Exhibit</u>
04/05/99	Princeton Community Hospital	DX11
Bilateral basal pneumonia and hypoxemia. Severe COPD with exacerbation and atelectasis and/or infiltrates.		
10/23/99	Princeton Community Hospital	DX11
Pneumonia, COPD, history of coronary artery disease and ulcer, history of severe reflux requiring a feeding tube.		
04/11/00	Princeton Community Hospital	DX11
Probable pneumonia, COPD, coronary artery disease, gastroesophageal reflux disease, hyponatremia, hypochloremia, probably secondary to diuretic therapy.		
02/01/01	Princeton Community Hospital	DX11
Right basilar pneumonia, chest pain, and dysuria.		

02/27/01	Princeton Community Hospital	DX11
Gastritis and vomiting, diarrhea, COPD, history of pulmonary fibrosis, coronary artery disease, history of gastroesophageal reflux.		
09/18/01	Princeton Community Hospital	DX11
Abdominal aortic aneurysm, no surgical intervention suggested in this bedridden COPD patient.		
11/15/01	Princeton Community Hospital	DX11
No acute surgical abdominal condition. Right lower quadrant ill defined mass.		
03/17/02	Princeton Community Hospital	DX11
Pneumonia, COPD, hyponatremia.		
05/29/02	Princeton Community Hospital	DX11
Methicillin resistant staph aureus, pneumonia, syndrome of inappropriate secretion of antidiuretic hormone, Parkinson's disease, urinary retention, COPD, and coronary artery disease.		
06/15/02	Princeton Community Hospital	DX12
Methicillin resistant staph aureus, severe end stage COPD, hypoxemia on chronic high flow oxygen, Parkinson's disease, urinary retention, and gastroesophageal reflux disease.		

## Findings of Fact and Conclusions of Law

### *Modification*

The instant survivor's claim was filed on December 22, 2002. (DX5) The Claimant has requested modification of a denial of a survivor's claim. Modification of a denial is based on a determination of a mistake of fact. The determination is based on a review of the evidentiary record relevant to the survivor's claim.

In a survivor's claim, the sole ground for modification is that there has been a mistake in a determination of fact. This is because there can be no change in the deceased miner's condition. The Board has yet to comprehensively define the phrase "mistake in a determination of fact." The Fourth Circuit Court of Appeals has stated that a request for modification may be based upon an allegation "that the ultimate fact ... was mistakenly decided." *See Jesse v. Director, OWCP*, 5 F.3d 723 (4<sup>th</sup> Cir. 1993). Therefore, the claimant's allegation that the claim was mistakenly decided is sufficient to support a petition for modification.

A mistake of fact analysis requires a review of all of the evidence of record. However, as the Board stated on remand, evidence from the prior miner's claim is not automatically available in a survivor's claim filed pursuant to the revised regulations. Medical evidence from the prior living miner's claims must have been designated as evidence by one of the parties, in order for it to have been included in the record relevant to the instant survivor's claim. BRB Decision and Order at 3. The Board vacated my admission into the record of the medical evidence from the miner's claims found at Director's Exhibits 1 and 2. Consequently, I must first determine whether the record of the instant survivor's claim includes the evidence from the miner's claim.

The evidence under consideration consists of medical reports, hospital treatment records and a death certificate. Because this is a modification request the evidentiary limitations at §725.310 apply as well as subsections (a)(2)(ii) and (a)(3)(ii) of §725.414. The relevant record includes all of the evidence in the record before the District Director at the time of the prior

denial as well as those designated by the parties for consideration in this modification request subject to the evidentiary limitations. The evidence before the District Director at the time of the prior denial consisted of several examination reports by Dr. Richard Slade as well as the Claimant's treating physician Dr. Pamela Faulkner. Included in the evaluation of the claim was a death certificate signed by the treating physician, Dr. Pamela Faulkner. No pulmonary function tests, blood-gas studies, or x-ray readings were submitted by the Employer or the Claimant for consideration by the District Director. In the most recent hearing, the Claimant designated one additional medical report by Dr. Rasmussen dated March 8, 2004. The Employer submitted three medical reports, one of them a rebuttal to Dr. Rasmussen's report.

### **Evidentiary Limitations**

The Board's remand mandates that I determine whether the record of the instant survivor's claim includes the evidence from the living miner's claim and discuss the evidentiary limitations at 20 C.F.R. § 725.414. As the Board stated, "...this case involves a survivor's claim, the medical evidence from the prior living miner's claims must have been designated as evidence by one of the parties, in order for it to have been included in the record relevant to the survivor's claim." A telephone hearing was held on April 9, 2007 to discuss the implications of the Board's remand and the evidentiary limitations discussed in the Board's Decision. Apart from Director's Exhibit 11<sup>6</sup>, although instructed to do so, neither the Employer nor the Claimant designated evidence from the living miner's claim to be admitted into the record.<sup>7</sup> During the hearing the parties were afforded an opportunity to designate evidence to be admitted into the record. Following the hearing, the record was left open for a period of time to allow the parties to submit evidence for consideration of the claim as well as briefs. In compliance with the Board's mandate, I find that in the absence of such a designation the evidentiary record from the living miner's claim is not part of the instant survivor's claim.

The evidence under consideration in this survivor's claim is that evidence before the District Director at the time of the prior denial and the evidence submitted as part of this modification request. Under 20 C.F.R. §725.310(b) each party shall be entitled to submit one additional x-ray reading, one additional pulmonary function test, blood-gas study, and medical report as part of the modification proceeding. Both parties were advised of the Board's recent decision in *Rose v. Buffalo Mining* interpreting the evidentiary limitations language of §725.310.<sup>8</sup> In *Rose*, the Board's interpretation of the term "additional" was construed to mean in addition to the limitations of §725.414. The Board held that either party was permitted to submit the full complement of evidence allowed by §§ 725.414 and 725.310 at any stage of the combined proceedings. The evidentiary limitations of §725.310 do not "supplant" §725.414, but rather "supplement" the limitations at §725.414. The effect of this ruling is to permit a party that has not submitted the full allowance of evidence in a particular category during its affirmative case to submit additional evidence on modification proceedings to the extent the evidence already submitted in the claim proceedings is less than the full complement allowed.<sup>9</sup>

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<sup>6</sup> DX11 consists of multiple treatment reports from Princeton Community Hospital.

<sup>7</sup> See transcript of telephone hearing held on April 9, 2007.

<sup>8</sup> See *Rose v. Buffalo Mining Company*, BRB No. 06-0207 (Jan. 31, 2007)

<sup>9</sup> As a general example, a party that had not submitted any x-ray interpretations during its affirmative case in an initial or subsequent claim may subsequently submit three x-ray interpretations in a modification proceeding because this represents the total number allowed when combining the limitations imposed by §§725.414 and 725.310.

Thus, both the Employer and the Claimant are allowed the full complement of evidence as permitted under §725.310(b) and §725.414. Neither party submitted x-rays for consideration in this modification proceeding. The Employer submitted one pulmonary function test and one blood-gas study, as well as three medical reports by Drs. Hippensteel, Spagnolo, and Zaldivar. The Claimant submitted one medical report by Dr. Rasmussen, and multiple hospital treatment reports. The record also contains a death certificate signed by the miner's treating physician, Dr. Faulkner. Both the Employer and the Claimant have complied with the evidentiary limitations of §§ 725.414 and 725.310(b) as interpreted by the Board's ruling in *Rose, supra*.

### ***Pneumoconiosis***

As an initial matter, the claimant has advanced the position that although collateral estoppel may not apply to the determination of the existence of pneumoconiosis, the establishment of pneumoconiosis in the living miner's claim should have a favorable effect on the determination of pneumoconiosis in the instant survivor's claim. In the miner's prior claim for benefits, the miner had established the existence of pneumoconiosis arising out of coal mine employment. While acknowledging that such a finding had been made in that claim, I must find that collateral estoppel does not apply to the issue of pneumoconiosis arising out of coal mine employment in this claim and the previous finding has no bearing on the determination of the existence of pneumoconiosis in the instant survivor's claim.

In order for the principles of collateral estoppel to apply to a claim, the following requirements must be satisfied. The issue to be precluded must be (1) the same as that involved in the prior action, (2) actually determined in the prior action and (3) essential to the final judgment in the prior action. In addition, the party against whom estoppel is invoked (4) must have had a full and fair opportunity to litigate the issue and (5) the prior judgment is final and valid. The doctrine of collateral estoppel does not apply to a legal ruling if there has been a major change in the governing law since the prior adjudication that could render the previous determination inconsistent with prevailing doctrine. See *Montana v. United States*, 440 U.S. at 161, 99 S.Ct. 970 (citing *Comm'r v. Sunnen*, 333 U.S. 591, 599, 68 S.Ct. 715, 92 L.Ed. 898 (1948)).

In *Collins v. Pond Creek Mining Co.*, 468 F.3d 213 (4th Cir. 2006), a widow sought to rely on collateral estoppel to establish the presence of coal workers' pneumoconiosis in her claim based on the fact that the miner was awarded benefits under the Act in his claim. As in this case, no autopsy evidence was offered in the survivor's claim. The Fourth Circuit ruled that a coal miner's widow seeking survivor's benefits under the Black Lung Act may generally rely on the doctrine of offensive nonmutual collateral estoppel to establish that, as a result of his work in the mines, her deceased husband had developed pneumoconiosis.

However, the Claimant did not move for the entry of the prior record in this case and therefore, collateral estoppel does not apply in this record.

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment. 20 C.F.R. § 718.201.

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or

substantially aggravated by, dust exposure in coal mine employment.” Thus, “pneumoconiosis”, as defined by the Act, has a much broader legal meaning than does the medical definition.

The claimant has the burden of proving the existence of pneumoconiosis. The regulations provide the means of establishing the existence of pneumoconiosis by: (1) chest x-ray evidence; (2) biopsy or autopsy evidence; (3) application of the irrebuttable presumption for “complicated pneumoconiosis” found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a)(1)-(4).

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy or autopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that section’s presumptions are applicable to a survivor’s claim filed after January 1, 1982, with no evidence of complicated pneumoconiosis.<sup>10</sup>

The Board found that I had erred in finding the existence of pneumoconiosis by x-ray at Section 718.202(a)(1), as the x-ray readings from the survivor’s claim that I considered were not classified according to the ILO classification system, and were therefore insufficient to establish the existence of pneumoconiosis at Section 718.202(a)(1). On remand, after I determine the evidence properly admitted in the instant survivor’s claim, I am to reconsider whether the x-ray evidence establishes the existence of pneumoconiosis pursuant to Section 718.202(a)(1). Pursuant to my finding that the evidentiary record in the living miner’s claim is not automatically made part of the survivor’s claim combined with the absence of new x-ray evidence, I no longer need to address this issue as there are no x-ray readings in the record to consider in this modification request.

The claimant may also establish the existence of pneumoconiosis if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the regulations. See *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). As a general rule, more weight is given to the most recent evidence because pneumoconiosis is a progressive and irreversible disease. See *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-166 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146 (1979).

Of the four physicians that submitted medical reports for consideration in this case, only Dr. Hippensteel failed to diagnose coal workers’ pneumoconiosis, stating that the “lack of consistency by the same radiologists does not speak of a process that is fixed or progressive as one would expect with coal workers’ pneumoconiosis.” In my prior Decision I concluded that besides Dr. Rasmussen and the treating physician, two of the three Employer’s physicians diagnosed pneumoconiosis. Therefore, I found that the claimant has established the existence of pneumoconiosis by a preponderance of the physician opinion evidence and x-ray evidence. On

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<sup>10</sup> The interpretation of the June 24, 2002 chest x-ray done while the miner was hospitalized in Princeton Community Hospital makes mention of complicated pneumoconiosis. However, I find this one interpretation that makes a passing reference to complicated pneumoconiosis insufficient to establish the existence of complicated pneumoconiosis. Furthermore, this chest x-ray does not conform to the ILO standards and has no probative value on the issue of pneumoconiosis.

remand the Board held that my finding that X-ray evidence and the remaining physician opinion evidence definitively establishes the existence of pneumoconiosis could not be affirmed because my finding that the evidence is sufficient to establish the existence of pneumoconiosis pursuant to Section 718.202(a)(4) was based on an improper weighing of the x-ray evidence at Section 718.202(a)(1) which necessarily affected my evaluation of the medical opinion evidence at Section 718.202(a)(4).

On remand, both parties have submitted only medical reports and hospital treatment notes. The x-ray evidence in the living miner's claim is not part of the evidentiary record in this survivor's claim; therefore, the only means by which to establish the presence of pneumoconiosis is by reasoned medical opinion. I have before me four medical reports prepared by Drs. Spagnolo, Zaldivar, Rasmussen, and Hippensteel. In addition, the Claimant has submitted multiple hospital treatment notes prepared by Dr. Faulkner (the miner's treating physician) and Dr. Slade.

In my prior decision I concluded that the preponderance of medical opinion evidence had established the presence of pneumoconiosis. However, on remand the Board mandated that I determine whether the evidentiary record from the living miner's claim has become part of the record in the instant survivor's claim. In the absence of any such designation by either party in this case, I have concluded that it has not. The exclusion of the evidentiary record from the living miner's claim affects the probative value which I assign to the medical reports submitted for consideration in the instant survivor's claim. All of the medical reports submitted by the Claimant and the Employer for evaluation reference evidence from the living miner's claim. The physicians' consideration of the excluded evidence is problematic. Under 20 C.F.R. §§ 725.414(a)(2)(i) and (3)(i) "any chest x-ray interpretation, pulmonary function test results, blood gas studies...and physician opinions that appear in a medical report must each be admissible..." under the regulations. All medical reports and records submitted by any party shall be considered by the administrative law judge in accordance with the quality standards contained in part 718 of subchapter C. 29 C.F.R. § 725.457(d). In *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-\_\_\_\_, BRB No. 04-0812 BLA (Jan. 27, 2006) (en banc), when confronted with a medical opinion that contained evidence not admitted into the formal record, the Benefits Review Board indicated that an administrative law judge may: a) exclude the report; b) redact the objectionable content; c) require a revised report; or d) consider the physician's reliance on the inadmissible evidence in deciding the probative value of the report. The living miner's claim contains a substantial amount of evidence dating as far back as 1972. Each physician preparing a medical report has reviewed a significant portion of this evidence. My options for assessing the relative weight of the medical opinions are limited not only because of the breadth of evidence that is covered in the medical opinions, but also because fairness dictates that I not engage in selectively redacting portions of the opinions I feel are based on inadmissible evidence when it is not apparent to what extent each opinion bases its conclusions on admissible versus inadmissible evidence. Similarly, the inability to gauge the extent of the physicians' reliance on inadmissible evidence diminishes the probative value of the respective medical reports. Thus, I accord little probative value to the medical opinions submitted for consideration in this survivor's claim.

What I am left with are the hospital treatment records/notes plus the death certificate. The miner was admitted to the hospital on multiple occasions for various complaints (vomiting, pneumonia, fever, abdominal mass, chest pain, shortness of breath.)<sup>11</sup> In nearly all of the visits the diagnosis on discharge included COPD and, in several instances, to pulmonary fibrosis. In

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<sup>11</sup> See DX11, hospital admission records of Princeton Community Hospital.

addition, the death certificate lists the immediate cause of death as cardiopulmonary arrest and end stage COPD/pneumonia. However, no explanation is given as to how this conclusion is reached. There are no autopsy or biopsy reports explaining the causes and circumstances of the miner's death. Dr. Pamela Faulkner signed the death certificate. Dr. Faulkner is not a pathologist and I take note of this fact in my evaluation of the certificate. However, I am mindful of the fact that Dr. Faulkner, the miner's treating physician, examined the miner on many of the visits to the hospital. Her numerous contacts and examination of the miner may give her greater insight into the miner's condition and her opinion should be given special consideration although not automatically entitled to greater weight. See *Sewell Coal Co. v. O'Dell*, Case No. 00-2253 (4<sup>th</sup> Cir. July 26, 2001) (unpub.) (citing to *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 440 (4<sup>th</sup> Cir. 1997) to hold that opinions of examining physicians, although not necessarily dispositive, deserve special consideration). Moreover, Dr. Faulkner's and Dr. Slade's conclusions are substantiated by the opinions of the other physicians, except Dr. Hippensteel. Drs. Rasmussen, Spagnolo, and Zaldivar all agree that there exists sufficient evidence to diagnose coalworkers' pneumoconiosis. There is near unanimous consensus regarding the establishment of clinical pneumoconiosis. What is at dispute is the contribution, if any, of coal mine dust to the respiratory impairment and whether it hastened the death of the miner.

Considering all of the evidence pertaining to the existence of pneumoconiosis, I find that the claimant has established the existence of pneumoconiosis by a preponderance of the evidence. See *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4<sup>th</sup> Cir. 2000).

#### ***Arising Out of Coal Mine Employment***

Once the miner is found to have pneumoconiosis, (s)he must show that it arose out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b).

The miner was employed in the coal mine for 36 ½ years. Given that there is no evidence to the contrary, the claimant is thus entitled to the rebuttable presumption that his pneumoconiosis arose out of coal mine employment.

Five of the six physicians rendering medical opinions regarding the miner's respiratory condition conclude that the evidence is sufficient for a diagnosis of clinical pneumoconiosis. One of the physicians, Dr. Hippensteel, does not reach this conclusion, and two of the physicians, Drs. Zaldivar and Spagnolo, find no causal nexus between coal mine dust and the miner's pneumoconiosis. The burden is on the employer to rebut the presumption that pneumoconiosis did not arise out of coal mine employment. While I do not completely discount Dr. Hippensteel's conclusions, I do give less weight to his opinion because it is based on premises contrary to my finding that the miner suffered from pneumoconiosis arising out of coal mine employment. See *Scott v. Mason Coal Co.*, 289 F.3d 263 (4<sup>th</sup> Cir. 2002) (citing to *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4<sup>th</sup> Cir. 1995); *Grigg v. Director, OWCP*, 28 F.3d 416 (4<sup>th</sup> Cir. 1994)) (It is proper for the administrative law judge to accord less weight to a physician's opinion that is based on premises contrary to the judge's findings.) Thus, I am left with determining whether the opinions of Dr. Spagnolo and Dr. Zaldivar are sufficient to rebut the presumption that pneumoconiosis arose out of coal mine employment.

There is very little discussion regarding causation and pneumoconiosis in Dr. Spagnolo's medical opinion. Dr. Spagnolo notes the miner's smoking history, the degree of lung function

measured on multiple occasions, and various blood gas studies which resulted in fluctuating values. Dr. Spagnolo's conclusions are that the miner did not have a respiratory impairment that would have prevented him from performing his last coal mine employment. Furthermore, Dr. Spagnolo emphasizes the multiple medical conditions suffered by the miner, including congestive heart failure, Parkinsons, dysphagia, and pulmonary emboli and states that coal mine dust exposure did not play a role in any disability he may have had prior to his death, and that the miner's death was unrelated to or hastened by pneumoconiosis. Dr. Spagnolo's conclusions focus on the relationship between the miner's medical condition and the degree of disability, as well as the contribution, if any, of a respiratory impairment in causing or hastening the death of the miner. Causation of pneumoconiosis is briefly mentioned when Dr. Spagnolo states that the miner's "medical conditions were those of the general public and are not related to his prior occupation or to coal dust exposure."

Dr. Zaldivar concludes that the evidence indicates that the miner suffers from coalworkers' pneumoconiosis and also pulmonary fibrosis. Dr. Zaldivar discusses the need for a lung biopsy and states that a lung biopsy is necessary to establish a diagnosis of pulmonary as well as the fact that pulmonary fibrosis may be idiopathic or it may be classified into the four other classifications which is usual interstitial fibrosis or desquamative interstitial fibrosis. Dr. Zaldivar quotes a statement that he asserts is germane to the situation of the miner in this case: "the current literature argues that in the absence of a surgical (thoracoscopic or open) lung biopsy, the diagnosis of IPF remains uncertain." Yet, later in the medical opinion, Dr. Zaldivar concludes that the pulmonary impairment present in the miner was pulmonary fibrosis, contributed by the miner's smoking history, and although the exact cause is unknown, it was certainly not caused or contributed by the miner's coal mine employment. Dr. Zaldivar also states that smoking causes pulmonary fibrosis. If a lung biopsy is necessary to diagnose pulmonary fibrosis, it is unclear how Dr. Zaldivar reaches a definitive conclusion that smoking contributed to the pulmonary fibrosis and the miner's 36 ½ years of coal mine employment did not. I find Dr. Zaldivar's opinion inherently inconsistent and accord it little weight on the issue of causation. A report may be given little weight where it is internally inconsistent and inadequately reasoned. See *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986).

Considering the evidence as a whole, I find that evidentiary record does not contain contrary evidence that rebuts the presumption that the miner's pneumoconiosis arose out of coal mine employment.

#### ***Death Due to Pneumoconiosis***

Subsection 718.205(c) applies to survivor's claims filed on or after January 1, 1982 and provides that death will be due to pneumoconiosis if any of the following criteria are met:

- (1) competent medical evidence established that the miner's death was due to pneumoconiosis; or
- (2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was by complicated pneumoconiosis; or
- (3) the presumption at § 718.304 [complicated pneumoconiosis] is applicable.

20 C.F. R. § 718.205(c). The regulations further detail that a survivor is not entitled to benefits if the miner's death was due to "a traumatic injury or the principle cause of death was not related to pneumoconiosis." 20 C.F.R. § 718.205(c)(4)(2001). The regulations go on to further state that if pneumoconiosis hastens the miner's death it falls within the purview of being a "substantially contributing cause" of the miner's death. 20 C.F.R. § 718.205(c)(5)(2001).

The regulations also provide for certain presumptions to aid a survivor in establishing the elements of entitlement necessary to receive benefits under the Act. The claimant cannot invoke the presumptions at §§ 718.303(c), 718.305(e) or 718.306(a) because the claim was not filed within the specified time period for the application of those presumptions. I have also found that complicated pneumoconiosis did not exist. Therefore, the irrebuttable presumption at § 718.304 is not applicable to this claim.

A death certificate, in and of itself, may be an unreliable report of the miner's condition and it is error to accept conclusions contained in such a certificate where the record provides no indication that the individual signing the death certificate possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death. *Smith v. Camco Mining, Inc.*, 13 B.L.R. 1-68 (1988). The Circuit Court of Appeals for the Fourth Circuit has held that the statement on a death certificate that pneumoconiosis contributed to the miner's death, without any further explanation is insufficient evidence to establish that the miner's death was due to pneumoconiosis. See *Bill Branch Coal Co. v. Sparks*, 213 F.3d 186 (4<sup>th</sup> Cir. 2000).

The miner's death certificate does not mention pneumoconiosis, but does acknowledge chronic obstructive pulmonary disease, COPD, as a contributing cause of the miner's death. (DX10). Later, the physician who signed the miner's death certificate drafted a letter stating that pneumoconiosis had hastened the miner's death. (DX26). Dr. Faulkner based this statement on the fact that the miner suffered from severe COPD as well as interstitial fibrosis. Dr. Faulkner was the miner's treating physician and is entitled to certain deference due to that relationship.

The record shows that the miner had been hospitalized in January, 1997, September, 1998, April, 1999, October, 1999, February 2001 and September, 2001. (DX11). The records substantiate a lengthy history of chronic obstructive pulmonary disease. The miner was initially given supplemental oxygen in 1997. Dr. Faulkner has been the attending physician but consultative examinations were performed, that upon testing, confirm the diagnosis. Office notes show that the miner was examined and treated for COPD. (DX12).

As noted, pursuant to 20 C.F.R. §718.104(d) Dr. Faulkner does not support her conclusions with sufficient logic as to her basis for "hastening". However, I find that the Claimant has demonstrated that Dr. Faulkner obtained superior and relevant information concerning the miner's condition. Therefore, I accord her opinion significant weight as to a diagnosis of COPD, but can not accord controlling weight to her statement that pneumoconiosis hastened the miner's demise.

Dr. Rasmussen believes that pneumoconiosis hastened the miner's death. Drs. Hippensteel, Zaldivar and Spagnolo do not believe that pneumoconiosis played any role in the miner's death.

According to Dr. Rasmussen, the miner suffered from a disabling and "ultimately fatal chronic lung disease" that was a consequence of both cigarette smoking, and coal dust exposure. The coal dust exposure was a "major and substantial" contributing factor in the miner's death. I find that Dr. Rasmussen misstated the amount of contribution from cigarette smoking. As I previously discussed, medical reports which reference the evidentiary record in the living miner's claim taint the opinion being rendered by the physician because the evidence referred to has not been admitted as part of the instant survivor's claim. There is evidence that shows the miner had blood gas studies indicating a pulmonary impairment which may have hastened the death of the miner. However, these tests are part of the evidence which has not been admitted and reference to them diminishes the probative value of the opinion. Accordingly, I attribute little weight to Dr. Rasmussen's opinion on the issue of death due to pneumoconiosis.

I discount Dr. Hippensteel's opinions as he is the sole physician to reject evidence of pneumoconiosis, and it is established that the miner had pneumoconiosis. See *Scott v. Mason Coal Co.*, 289 F.3d 263 (4th Cir. 2002); *Cannelton Industries, Inc. v. Director, OWCP* [Frye], Case No. 03-1232 (4<sup>th</sup> Cir. Apr. 5, 2004) (unpub.); see also *Soubik v. Director, OWCP*, 366 F.3d 226 (3<sup>rd</sup> Cir. 2004).

I discount Dr. Zaldivar's opinion for three reasons. First I note that only Dr. Zaldivar finds that the miner had idiopathic pulmonary fibrosis. I note that Dr. Zaldivar is as well qualified as Drs. Spagnolo and Dr. Rasmussen, but I find that his diagnosis is not rational as it is evident that the miner had COPD. I note that the X-rays that Dr. Zaldivar rely upon to diagnose pulmonary fibrosis were also read as having COPD. EX3, at pages 8 to 10. Dr. Zaldivar may be a "B" reader, but the majority of well qualified readers found COPD. Moreover, the miner had been treated for COPD during his lifetime and he had symptoms consistent with COPD, such as wheezing and ronchii, cough and production of sputum. DX 11, DX 12. Dr. Zaldivar does not explain how these symptoms differ from those caused by pneumoconiosis. Moreover, the testing he relies upon to render his diagnosis, principally pulmonary function testing, come from the prior record and are not recent. Therefore, I find that Dr. Zaldivar's diagnosis is contrary to the full weight of the evidence.

Second, I note that Dr. Zaldivar found existence of pneumoconiosis but states:

There was a pulmonary impairment present. The pulmonary impairment present was not related to his occupation as a coal miner. EX 3.

Dr. Zaldivar maintains that the pulmonary impairment, stems from idiopathic pulmonary fibrosis rather than pneumoconiosis. In *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996), the court reiterated that "[c]linical pneumoconiosis is only a small subset of the compensable afflictions that fall within the definition of legal pneumoconiosis under the Act" and that "COPD, if it arises out of coal mine employment, clearly is encompassed within the legal definition of pneumoconiosis, even though it is a disease apart from clinical pneumoconiosis." See also *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000) (the court emphasized the distinction between legal and medical pneumoconiosis; a miner's exposure to coal mine employment must merely contribute "at least in part" to his pneumoconiosis). Dr. Zaldivar also states that that a lung biopsy is necessary to establish a diagnosis of and the extent of pulmonary fibrosis "which ... may be idiopathic or it may be classified into the four other classifications which is usual interstitial fibrosis or desquamate interstitial fibrosis or nonspecific interstitial fibrosis." I find that this opinion does not rule out competently produced "hastening". To the contrary, if testing is needed to substantiate his thesis, one can infer that there is a possibility that pneumoconiosis is competent to produce the pulmonary impairment that Dr. Zaldivar admits is present in the record. Moreover, the other forms of pulmonary fibrosis may be considered to be "legal" pneumoconiosis.

Third, Dr. Zaldivar stated that most people suffering from simple coal workers' pneumoconiosis do not suffer from any significant respiratory impairment. He also states that pulmonary fibrosis is *not* related to pneumoconiosis. A conclusion that simple pneumoconiosis cannot be totally disabling has been deemed hostile to the spirit of the Act. See *Searls v. Southern Ohio Coal Co.*, 11 B.L.R. 1-161 (1988); *Butela v. U.S. Steel Corp.*, 8 B.L.R. 1-48 (1985); see also *Thorn v. Itmann Coal Co.*, 3 F.3d 713 (4th Cir. 1995) (the physician stated that 'simple pneumoconiosis' does not cause total disability 'as a rule' was hostile-to-the-Act).

I note that in *Lane v. Union Carbide Corp.*, 105 F.3d 166 (4th Cir. 1997), the court held that a physician's opinion was not 'hostile-to-the-Act' where the physician concluded that simple

pneumoconiosis would 'not be expected' to cause a pulmonary impairment. He distinguishes among several types of pulmonary fibrosis, but in so doing, I find that Dr. Zalvidar failed to consider any possibility of "hastening" in this case. See *Piney Mountain Coal Co. v. Mays*, 176 F.3d 753, 760 n. 7 (4th Cir.1999) (doctor's testimony that "simple pneumoconiosis cannot cause, substantially contribute to, or hasten death" amounts to a belief that no one is entitled to benefits under the Black Lung Act. I find that the statement that pulmonary fibrosis is *not* related to pneumoconiosis (see Ex 3, page 10) as hostile as "simple pneumoconiosis cannot cause" hastening in *Piney Mountain*. I also note that the regulations were amended in 2000, and that a presumption of progressivity is recognized. 20 C.F.R. §718.201.

I discount Dr. Spagnolo's opinion because his opinion is based on a finding that prior to leaving his coal mine employment, the miner's pulmonary function testing showed no obstructive or restrictive impairment, and therefore, the "most likely" explanation for the miner's fluctuating blood gas values was cardiac disease. I note that this also conflicts with the regulation which states in part:

For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201(c). There is no explanation for this proposition. The miner left work in the 1980's. The implication is that pneumoconiosis is not progressive, which is contrary to law. Therefore, I find that Dr. Spagnolo failed to account for the presumption of progressivity.

I also note Dr. Spagnolo takes issue with the miner having been diagnosed as suffering from COPD as he sees no evidence of obstructive pulmonary impairment in the miner. (EX 7, p. 22). However, again treatment records show that the miner had been treated for COPD during his lifetime and he had symptoms, such as cough and production of sputum. DX 11, DX 12. This opinion varies with the fifteen X-ray readings of record, the treatment records and hospital records, without a full explanation why his position may be more valid than the treating physician who treated the miner for COPD and prescribed oxygen due to hypoxemia. I credit Dr. Faulkner's diagnosis of COPD and therefore I discount Dr. Spagnolo's opinion on this point. Both Dr. Spagnolo and Dr. Zalvidar rest their opinions in large part on testing performed years before the miner had expired. The last test they reference was performed in 1987. Moreover, that testing was determined to be invalid. Therefore, complete reliance on old testing is not warranted.

The burden is on the Claimant to establish, by a preponderance of the evidence, that the miner's death was due to pneumoconiosis. Although I find the medical opinions of the Employer's physicians of little probative value, it is the Claimant who bears the burden of proof on this issue. See *Oggero, supra*. Dr. Faulkner's conclusions regarding the cause of death are not well articulated. The mere reference to COPD as a cause in the death of the miner is insufficient to meet the burden of proof that COPD hastened the death of the miner. I find that the claimant has failed to establish that pneumoconiosis was a substantially contributing cause of the miner's death or that it hastened the death of the miner.

### **Conclusion**

The Claimant has proven, by a preponderance of the evidence, the presence of pneumoconiosis and that pneumoconiosis arose out of coal mine employment. However, the Claimant has failed to establish that the miner's death was due to pneumoconiosis. After review of the evidence, I do not find a mistake of fact.

## **ORDER**

It is ordered that the claim of **IB**, widow of **FB**, for survivor's benefits under the Black Lung Benefits Act be hereby **DENIED**.

**A**

DANIEL F. SOLOMON  
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with this Decision and Order you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which this Decision and Order is filed with the district director's office. See 20 C.F.R. §§725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C. 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor for Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210. See 20 C.F.R. §725.481.